Michigan Department of Health and Human Services

Medicaid State Plan

The Michigan Medicaid State Plan is an agreement between the State of Michigan and the federal government which identifies the general health care services, reimbursement of those services and the beneficiary and provider eligibility policies in effect under Michigan's Medicaid program.

The Centers for Medicare and Medicaid Services (CMS) of the Department of Health and Human Services is the federal agency with oversight responsibility of the Medicaid Program. All parts, including updates or changes to the Plan, must be approved by CMS in order to become effective. Federal regulations detailing the State Plan purpose and maintenance procedures may be found at 42 CFR 430 Subpart B.

The State Plan posted here is available for information purposes only; it does not replace the official version and does not contain any pending amendment information or amendments approved since January 1, 2019.

Amendments pending approval or approved since January 1, 2019 may be found at:

www.michigan.gov/mdhhs >> Inside MDHHS >> Budget and Finance >> Medicaid Waiver & State Plan Amend. Notification

http://www.michigan.gov/mdhhs/0,1607,7-132-2946_5080-108153--,00.html

Questions regarding the State Plan may be e-mailed to:

MSAPolicy@michigan.gov

The following table identifies the sections of the State Plan and a brief overview of each.

1	Single State Agency Organization	provides information regarding the State's designation of the Michigan Medicaid Single State Agency, the authority under which it operates and a description of the organization.
2	Coverage & Eligibility	outlines Michigan Medicaid's eligibility conditions such as income, resources, assets and the various groups (i.e. aged, blind, disabled and family independence program)
3	Amount, Duration and Scope of Services Provided	Attachment 3.1-A lists the services covered under the Michigan Medicaid program and the Supplements to Attachment 3.1-A provide a more detailed description of those services, including any limitations or requirements to/for that coverage
4	General Program Administration	Medicaid reimbursement methodologies takes up the bulk of Section 4; specifically Attachment 4.19. Attachment 4.19-A provides a full description of inpatient hospital reimbursement, Attachment 4.19-B explains reimbursement to all providers except inpatient hospital and long term care facilities. Attachment 4.19-D covers Medicaid payment for long term care facilities.

SECTION — PAGE NUMBERS

Revision: HCFA-AT-80-38(BPP)
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State MICHIGAN

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AT-78-90

4.16 Relations with State Health and Vocational Rehabilitation Agencies and Title V Grantees

The Medicaid agency has cooperative arrangements with State health and vocational rehabilitation agencies and with title V grantees, that meet the requirements of 42 CFR 431.615.

ATTACHMENT 4.16-A describes the cooperative arrangements with the health and vocational rehabilitation agencies.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Michigan

COOPERATIVE ARRANGEMENTS WITH STATE HEALTH AND STATE VOCATIONAL REHABILITATION AGENCIES AND WITH TITLE V GRANTEES

I. MICHIGAN DEPARTMENT OF PUBLIC HEALTH

Agreement, effective December 26, 1980

II. MICHIGAN DEPARTMENT OF MENTAL HEALTH

Agreement, effective September 22, 1977

III. MICHIGAN DEPARTMENT OF EDUCATION, BUREAU OF REHABILITATION

Interim agreement, effective September 30, 1980

IV. MICHIGAN DEPARTMENT OF PUBLIC HEALTH, AND MICHIGAN DEPARTMENT OF STATE POLICE, FIRE MARSHAL DIVISION

Agreement, effective May 24, 1979

CONTRACT BETWEEN THE MICHIGAN DEPARTMENT OF SOCIAL SERVICES AND THE MICHIGAN DEPARTMENT OF PUBLIC HEALTH

Pursuant to Act 280, Public Acts of Michigan of 1939, as amended, a Medical Assistance Program has been implemented in the State of Michigan as authorized by the federal Social Security Act, as amended.

In order to fully comply with the provisions of the above legislation, with reference to appropriate and related federal requirements and with the mandates of Executive Order No. 1965-29 dated December 9, 1965 and subsequent attachments thereto, this contract is entered into by the Michigan Department of Social Services, hereinafter referred to as "Social Services" and the Michigan Department of Public Health hereinafter referred to as "Public Health".

ARTICLE I

It is the intent and purpose of the parties hereto, by entering into this contract: to promote high quality health care and services for recipients under the Medical Assistance Program; to comply with state and federal statues, regulations and guidelines requiring the proper expenditure of public funds for the administration of a Medical Assistance Program and certification of health care providers; to provide a mechanism for prior authorization of selected services; to assure that the services provided under Title XIX and Title V are consistent with the needs of recipients and the two programs' objectives and requirements.

ARTICLE II

The Directors of Social Services and Public Health shall designate from their staffs appropriate liaison persons whose responsibilities shall include regular and periodic communication about the programs and operations described in this contract. Overall liaison responsibilities shall be vested in the Director of Medical Services Administration, Social Services, and the Chiefs of the Bureau of Health Care Administration, and the Bureau of Personal Health Services, Public Health. These persons may delegate liaison responsibilities for programs or operations specified in the sections of Article III, below.

The liaison persons shall be responsible for the joint planning of relationships between the two agencies. They shall oversee the investigation of any problems that arise from the operation of this contract. They shall cause to be undertaken annually a review of the effectiveness of the working relationships defined in this contract, and shall initiate jointly any amendments to this contract.

ARTICLE III

The broad fundamentals of responsibilities and duties of the parties to this contract are subject to the terms and conditions contained in the sections below.

Section A - Budget Review and Comment
Section B - Certification of Medical Assistance Providers
Section C - Medical Review and Independent Professional Review (MP/IPR)
Section D - Early and Periodic Screening, Diagnosis & Treatment (EPSDT)
Section E - Medical Assistance and the Crippled Children Program
Section F - Medical Assistance and Title V Projects
Section G - Trust Fund Procedures

A. Budget Review and Comment

This section provides for Social Services review of, and the opportunity for comment on, Public Health's Proposed budget request as it pertains to the functions covered by this contract.

PUBLIC HEALTH WILL:

Forward to Social Services copies of the Public Health annual budget request and any program revision requests insofar as those requests pertain to the functions covered by this contract.

The copied portions of the budget request will be forwarded to Social Services upon completion but no later than the date that Public Health's budget request is transmitted to the Department of Management and Budget.

SOCIAL SERVICES WILL:

Comment on Public Health's budget request and program revision requests to Public Health and Management and Budget.

B. Certification of Medical Assistance Providers

In order to promote high quality of health care and services for recipients of Michigan's Medical Assistance Program, to assure the proper expenditure of public funds for health care and services provided said recipients and to conform with applicable state/federal requirements, this section provides a mechanism for certification of health facilities, institutions, agencies and other providers of medical service by Public Health to Social Services. The certification activity is contractually delegated to the Bureau of Health Care Administration, Public Health. The reports are used by the Medical Services Administration, Social Services, to assure proper payment of claims submitted by certified providers.

Section B pertains to providers of medical service which require certification as a basis for participation under Michigan's Medical Assistance Program administered by Social Services. Such certification will indicate that certified providers meet applicable state and federal standards for participation in the Medical Assistance Program.

Public Health will certify the following providers to Social Services and others as may be required from time to time as identified in Addenda to this section. Such certification does not mean that services provided by

are incorporated as covered services under Michigan's State Plan for Medical Assistance.

1. Hospitals, including public and private psychiatric hospitals and psychiatric units of general hospitals.
2. Nursing homes.
3. County medical care facilities.
4. Hospital long-term care units.
5. Nursing care units in state MI/MR institutions.
6. Home health agencies.
7. Laboratories.
8. Ambulance services.
9. Freestanding surgical outpatient facilities.
10. Physical therapy clinics and physical therapy practitioners.
11. HMOs.

PUBLIC HEALTH WILL:

1. At appropriate intervals as prescribed by state and federal regulations, conduct on-site surveys, re-surveys and other necessary examinations of the providers identified above applying to or already participating as providers of service under the state's Medical Assistance Program, for purposes of determining their compliance with program requirements for certification as providers.
2. Certify and recertify to Social Services, in accordance with federal regulations and the Michigan Public Health Code, those providers which meet applicable federal and state statutes and regulations. The methodology of survey, evaluation and certification will also comply with applicable statutes, regulations and the provisions of this section and be subject to review and comment by Social Services.
3. Notify Social Services and the individual provider within 5 working days of a certification determination and 30 calendar days prior to the expiration or automatic cancellation date of a time limited certification. Such notifications shall be made by a document process mutually agreed upon by both departments and shall include information sufficient enough in detail as to allow Social Services to carry out appropriate provider agreement action as mandated by federal regulations. This document process shall also allow for extensions of existing certifications as provided for in federal regulations.
4. Annually provide to Social Services a complete listing of all certifications in effect on January 1 of that year.
5. Determine and authorize any waiver of provider requirements granted, the conditions of the waiver and the time period such waiver will be in effect.

Vernice Davis Anthony, Director
Michigan Department of Public Health

for Gerald H. Miller, Director
Michigan Department of Social Services

Date

Date

TN No. 91-33 Approval Date 1-23-92 Effective Date 10-01-91

Supersedes
TN No. N/A

6. Maintain on file for three years all information and reports used in determining a provider's compliance with certification requirements. Such reports will include copies of the findings of those making on-site inspections, documentation of deficiencies and copies of official notices of waiver of any requirements.

7. Provide an appeal procedure for use when the provider is in disagreement with the evaluation of its compliance with certification requirements.

8. Delineate and approve the scope of services to be provided by health facilities, institutions and agencies as follows:

   a. With the assistance of appropriate professional organizations and agencies, develop standards and criteria for the provision of services by hospitals, nursing homes, medical care facilities, agencies, laboratories and other health facilities, institutions and agencies certified to provide care and services under the Medical Assistance Program.

   b. With the assistance of physician staffs and boards of trustees, as well as specialty consultants and local health officers as indicated, apply those standards and criteria to health facilities, institutions and agencies desiring to become providers of services under the Medical Assistance Program and other programs administered by Social Services.

   c. Certification shall include delineation and approval of the type of services and level of care, where applicable, which each facility or agency shall be authorized to provide under the Medical Assistance Program.

9. Provide to Social Services upon request and on a timely basis all reports necessary to meet federal reporting requirements.

10. Maintain data reporting procedures for determining expenditures in which federal financial participation is available.

SOCIAL SERVICES WILL:

1. Utilize as one of the determinants for provider enrollment, disenrollment and payment purposes the certification of providers or denial of such certifications made by Public Health to assure that reimbursement is made for health care and services rendered by providers meeting minimum accepted standards including the fire safety inspection.

2. Exercise ultimate authority to enroll or disenroll provider facilities and agencies in the Medical Assistance Program.

C. Prior Authorization, Medical Review and Independent Professional Review (MR/IPR)

This section provides for interdepartmental and multidisciplinary professional review and evaluation of the health status and care needs of eligible or potentially eligible Medical Assistance clients prior to and periodically following admission to skilled nursing and intermediate care facilities except those facilities for which MR/IPR has been contracted to the Michigan Department of Mental Health (MDMH) to perform for Social Services. In addition, an evaluation shall be made of the appropriateness of care provided by the facility to the client, the facility's adequacy in meeting the client's current care needs and the necessity and desirability of the client's continued placement in the facility.

The program shall be designed and operated to conform to requirements for MR/IPR set forth in federal regulations. Scheduling will involve consultation with local office staff of both agencies.

PUBLIC HEALTH WILL, IN COOPERATION WITH AND WITH THE APPROVAL OF SOCIAL SERVICES:

1. Provide nurse personnel, and where appropriate, a physician to provide consultation to the team, to participate in the MP/IPR prior authorization, periodic and interval review and evaluation processes.

2. Provide a system for recommending the appropriate level of care to be prior authorized for eligible or potentially eligible recipients admitted to, or seeking admission to, certified skilled nursing or intermediate care facilities except those facilities for which MR/IPR is performed by MDMH.

   a. Specify, in agreement with Social Services, the medical information and documentation to be received as part of the application for prior authorization.

   b. Evaluate medical information and documentation received as part of application for prior authorization. Recommend to Social Services the level of care determination made for the individual client's needs. This determination serves as the medical justification for payment at that level of care.

   c. Notify Social Services, the facilities to which the client is or is about to be admitted, local health departments, and others as appropriate regarding the prior authorization of level-of-care recommendation.

   d. Within 5 working days of the recommendation, distribute the level-of-care recommendation to specified parties.

3. Provide a system of periodic and, as required, interval review and evaluation of Medical Assistance clients in skilled nursing and intermediate care facilities. Such reviews shall be performed at least annually in each facility with the schedule monitored by Social Services to insure compliance with federal regulations as well as Social Services' participation. The review and evaluation, conducted by a nurse and other appropriate personnel, shall include:

   a. Personal contact and observation of each client and a review of each client's plan of care and appropriate associated medical records.
   b. Consultation, when indicated, with the responsible attending physician and the utilization review committee chairperson or designated agent, in skilled facilities, and at the conclusion of each review a team exit conference with the facility administrator and other appropriate staff.
   c. Forwarding of facility reports to Social Services within 15 days after the end of the month in which the annual reviews were conducted.
   d. Contribution to the annual facility review reports by Public Health and Social Services inspection team members. These reports shall be transmitted to Social Services within 15 days of the close of the month in which the review was done.

4. Semi-annually consult with, and obtain continuing approval from, Social

Services with respect to the functioning of the program.

5. Provide Social Services with reports necessary to fulfill federal reporting requirements within time frames established by the two departments.

6. Provide Social Services with statistical reports on MR/IPR as may be required under Social Services responsibilities.

7. Maintain necessary Medical Assistance Program files to ensure appropriate continuity of program responsibility. Immediate access to files will be afforded to both Public Health and Social Services.

8. Provide professional testimony for administrative hearings and in cases of litigation on all disputed level-of-care determinations.

9. At the request of Social Services participate in meetings, including those with Professional Standards Review Organizations, or entrance and exit interviews with federal agencies, when discussion involves the MR/IPR program.

SOCIAL SERVICES WILL:

1. Participate in MR/IPR and provide social evaluations and assessment of alternatives to facility care for clients during the prior authorization, and annual inspection and evaluation process.

2. Assist clients and their families in locating necessary community resources and appropriate placements to allow for the implementation of alternate care plans recommended by MR/IPR personnel.

3. Forward a copy of each annual facility inspection report filed by the interdisciplinary team leader to the facility and its functioning utilization review committee.

4. Take appropriate action on recommendations submitted by MR/IPR personnel.

5. Conduct administrative hearings to resolve formal appeals of disputed level-of-care determinations.

6. Participate in periodic program evaluations with Public Health as described in point 4 of the responsibilities of Public Health.

7. Maintain necessary files to ensure appropriate continuity of program responsibility. Immediate access to files will be afforded to both Public Health and Social Services.

8. Advise Public Health of meetings, including those with Professional Standards Review Organizations, or entrance and exit interviews with federal agencies, when discussion involves the MR/IPR program.

D. Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

In order to promote a comprehensive, preventive health care system for children eligible for services under Michigan's Medical Assistance Program (Medicaid), to assure the proper expenditure of public funds for health care and services provided said recipients, and to conform with applicable state and federal requirements, this section provides for a program of early and periodic screening, diagnosis and treatment (EPSDT) for eligible Medicaid recipients under age 21

to ascertain physical and developmental abnormalities, and to treat, correct or ameliorate abnormalities and chronic conditions found.

EPSDT is defined herein to include, at a minimum, the following services mandated by federal regulation:

1. Informing eligible recipients of the availability of EPSDT services;
2. Health screening according to an established periodicity schedule;
3. Diagnosis and referral services;
4. Identification, informing, and referring of recipients eligible for Title V services;
5. Treatment for defects and conditions discovered, including services not otherwise available to other Medicaid recipients;
6. Transportation, upon request, to and from screening, diagnostic, and treatment sites; and
7. Documentation of the administrative process and clinical data resulting from these efforts.

Screening components, periodicity schedules, professional performance standards and review procedures, administrative procedures, and manuals will be developed by Public Health in mutual agreement with Social Services. Review procedures will be implemented in a manner consistent with the professional perspectives and responsibilities of the public health care system and in accordance with applicable federal and state statutes, rules and regulations.

PUBLIC HEALTH WILL:

1. Screening, Referral, and Follow-up

   a. Develop screening content, procedures and standards:

      Professional health staff will develop and recommend content, frequency, and standards for screening services and evaluation data in cooperation with other medical, dental, and health representatives as appropriate. Content and standards will include, but need not be limited to, all services required by federal regulations; additional services may be provided at the option of screening providers with prior approval of Social Services. Frequency of screenings will be based on a periodicity schedule developed to provide screening intervals appropriate to age and stage of development. Special consideration will be given to steps required to make services available to handicapped individuals.

   b. Assure the availability of screening services:

      The availability of screening services on a statewide basis and the delivery of services at the local level will be accomplished through contracts and subcontracts approved by Social Services. Each such (sub)contract is to be reviewed and renegotiated annually and must specify the responsibilities, staff and other resources, and a detailed budget conforming with section C, below. Public Health will forward a copy of the signed contract to Social Services. Screening sites may

be located at local health department clinics. Designated staff will have responsibility for day-to-day operation of the screening functions, including administrative and clinical performance. Periodically, the operation of clinics statewide will be evaluated and monitored by Public Health staff through the analysis of reports, data and on-site visits as needed. Reports of significant negative findings, together with recommended corrective action, will be forwarded by Public Health central office to Social Services within 60 days of the completion of each such analysis.

The screening clinic will provide local Social Services with a schedule of available screening times at least one month in advance for use by Social Services in scheduling client appointment times and preparing daily screening schedules for the clinic. Clinic staff will notify Social Services, within one working day, of an individual's failure to keep an appointment by completing and returning the daily screening schedule.

c. Assure that the established services are provided and recorded:

1) Screening procedures will be performed by specially trained clinic teams, which are staffed according to formulas designed to assure adequate screening.

2) Results of each client's screening and any referral information will be recorded on a screening summary form, agreed to by Social Services, which will be sent to central office within a designated period of time after completion of the screening. Data from the summary will be placed on computer file after evaluation and an analysis by central office staff; Social Services generates the reports for use by Public Health central office and local health department staff in follow-up and monitoring activities.

3) Clinic staff will: a) screen clients; b) interpret results to families; c) assist in completing health history forms, when necessary; d) offer assistance to families in locating and selecting appropriate medical resources and arranging appointments as necessary; e) offer assistance in utilizing medical resources effectively; and f) identify those clients eligible for Title V services, referring them as appropriate.

4) Clients will be referred by the clinic to medical/health providers for further evaluation and treatment when indicated by screening results. Referral information (including the provider type and provider ID number of the provider to whom referral is made) and date of appointment will be recorded on the client's screening summary, prior to the form's submission to central office. Such referral data will be placed on computer file and periodically matched with the Social Services medicaid claims file to verify that treatment has been initiated. If no match is made, indicating treatment has not been initiated, a non-treatment report will be generated by Social Services and sent to the screening clinic for follow-up.

5) Upon receipt of a non-treatment report, clinic staff will follow-up with clients so referred to them and will prepare an outcome report identifying an outcome for each referral client. Follow-up will

also occur whenever a client chooses to make his/her own appointment.

2. Outreach, Training and Transportation

   a. Contract with local health departments or other health care delivery organizations for the provision of outreach and scheduling services with approval of Social Services. Such contracts are to be reviewed and renegotiated annually with outreach staffing allocated according to the formula in 3.d.2) below.

   b. Forward to Social Services proposals for outreach services at the local level with Public Health's recommendations for approval, rejection, or conditions of acceptance.

   c. Monitor outreach activities performed by local health departments and other health care organizations and report any significant negative findings and recommendations for corrective action, to Social Services.

   d. Provide training programs for, and the monitoring of, screening and outreach teams as needed.

   e. Offer assistance to families in arranging transportation for referrals. If transportation assistance is requested, clinic staff will inform outreach workers by forwarding a referral-for-services form; outreach workers then arrange transportation.

3. Fiscal Control, Documentation and Reporting

   a. Develop and implement budget proposal format and procedures which assure:

      1) Adequate detail to reflect the previous, current, and projected years' costs by agreed-to line items;
      2) Narrative explanation of each projected increase or decrease;
      3) Provision of a rationale for any budgetary increases; and
      4) Availability of work papers upon request.

   b. Submit all local contract proposals and significant budget amendments to Social Services, allowing a one month lead time for approval. Annual budget requests and any program revision requests shall be developed in cooperation with Social Services to facilitate consistency between the two department's budgets. All local EPSDT contracts shall be coincident in duration and termination date with the state fiscal year.

   c. Promulgate a formula agreed to be Social Services, for staffing patterns, to local health department clinics and other health-care providers involved in screening, outreach and transportation services. The standard formula follows:

      1) Clinic staff: One (1) clerk for every 4,000 contracted screening appointments, One (1) nurse for every 4,000 contracted screening appointments, One (1) technician for every 2,000 contracted screening appointments, One (1) budgeted nurse position for every 8,000 contracted screening and appointments for follow-up, One (1) clinic aide for every 4,000 contracted screening appointments (or more

where previously approved) and sufficient staff for back-up to work a minimum of 4 hours per month to maintain skills. When contracted screening appointments total less than 4,000 per contract, staffing levels will be a percentage of the formula, as agreed upon by Social Services.

2) Outreach staff (when performed by Public Health): For every 1,000 contracted screening appointments at a given site, one outreach coordinator; for every additional 1,000 contracted screening appointments, one Public Health field representative; for every 4,000 contracted screening appointments, one full-time transporter and one full-time clerk.

e. Reimburse local contractors for actual costs incurred in fulfilling EPSDT (sub)contracts, such as reimbursement not to exceed the amount of the local contract or the state EPSDT appropriation.

f. Develop and implement methods for the maintenance of financial records in accordance with currently accepted accounting principles. For each of the first three quarters of the year, report expenditures data, in the aggregate, to Social Services.

g. During the last quarter of the fiscal year, report expenditure data, by (sub)contract and in the aggregate, monthly to Social Services. Comparison of expenditures to approved budgets will be shown on these reports. If expenditures appear to be exceeding approved budgets for the fiscal year, corrective action must be recommended for Social Services consideration.

h. Provide Social Services with monthly information on screening results, including: clients screened, clients referred for diagnosis and treatment, and other information regarding screening and outcome required for effective program management, federal reporting requirements, and other written documentation which may be found necessary by either agency at the central or local level.

i. Require that overscheduling, at a rate of at least 25% over capacity, be allowed in clinics where average attendance is less than 80% of optium capacity.

4. Program Coordination

Designate a staff member to serve as EPSDT coordinator and liaison with Social Services.

5. Other Program Operations

Provide whatever assistance is necessary to Social Services, through outreach and scheduling activities and data collection, to ensure that federal requirements are met with regard to the informing of clients, completion of screenings within established time limitations, and identification of clients eligible for services under Title V programs.

SOCIAL SERVICES WILL:

Local staff will perform activities related to client contact (e.g., eligibility, outreach, and scheduling) and access to screening/referral services, and

training while central office staff will carry out functions related to planning and management, computer systems and budget.

1. Eligibility Determination and Outreach

Assure that the following services are provided at the local level, by outreach workers or other local office staff:

a. Eligibility determination: Workers will determine eligibility of individuals for the Medical Assistance Program, see that eligibility status is entered and updated on central computer files, and assist clinic staffs or providers with eligibility questions.

b. Informing and outreach:

1) Social Services will consider Public Health proposals for outreach services, using the following criteria: a) completeness and rationale of the proposal, b) cost effectiveness, c) adherence to the established staffing formula, d) local Social Services effectiveness and position on the proposal, and e) other pertinent factors.

2) Outreach staff will inform those eligible for medical assistance of the availability of EPSDT services and encourage/facilitate participation. On a monthly basis, computer generated informing letters will be sent to clients appropriate for screening; a list of these clients will be sent to local offices for locally initiated contact. As clients call the local office in response to the letter, workers will discuss the program, answer their questions and schedule screening appointments. Workers will contact those clients who do not respond to the letter. Face-to-face contact per written procedures will be made on all new or re-opened cases. Special procedures will be used for informing blind, deaf or illiterate clients.

c. Scheduling: Using a screening time schedule provided by the clinic, workers will schedule screening appointments for clients or reschedule as necessary. With the exception of a relatively small number of walk-ins, all clients who wish to be screened will be scheduled for a specific time at a specific clinic. Clients will be assisted in completing health history forms prior to the clinic visit. Daily screening schedules, listing individual appointments, will be prepared and sent to screening clinics five working days in advance; such listing will also provide clinic staff with client information necessary for completing screening summaries. For all clients who are appropriate for screening but are not screened for any reason, workers will prepare a Refusal Notice (EPSDT), identifying reasons for nonparticipation and date of refusal, to be placed on file for future reference and follow-up. When advised by screening clinics of missed appointments, workers will contact clients to determine reasons and seek to eliminate barriers to participation, and reschedule if appropriate..

d. Supportive services: To facilitate attendance at screening appointments, workers will offer and arrange transportation for clients as needed; on referrals from local health departments/clinics, provisions will be made for transportation, child care or other supportive services to facilitate diagnostic and treatment appointments.

2. Information Services

a. Maintain a computerized reporting and monitoring system, to ensure all clients are systematically and periodically contacted regarding EPSDT, and to furnish to local offices:

1) A listing of eligible clients, distributed monthly, providing a master list of clients eligible for screening or rescreening.

2) Case summary report, distributed monthly, also listing eligible clients, to facilitate documentation of local office activities in attempting to screen clients. The form will be completed for all families contacted and retained as permanent record of a family's program experience.

3) Outreach case management report, distributed monthly, to identify the number of clients forwarded to local offices as appropriate for screening, and the outcomes. Clients due for screening must either be screened or their nonparticipation must be documented on a Refusal Notice.

4) Other lists and reports needed to effectively perform outreach, scheduling and follow-up activities, and to meet federal requirements for reporting, documentation, and maintenance of complete client records.

b. Provide accurate lists of clients due for screening to local health departments or other organizations performing outreach functions.

c. Provide to Public Health a list of enrolled Medical Assistance providers by county and such additional information as may be required and agreed upon, to implement, maintain and evaluate the screening program.

d. Maintain a record of expenditures for the diagnosis and treatment portion of the program to document client participation in the program and the accruing costs.

3. Contracts and Budget

a. Central office Social Services will review all local health department contract proposals within one month, with input from local Social Services offices; agree on number of appointments to be made available, by county, as well as the anticipated contract costs, by health district and state total. Approvals of screenings and budgets shall be within the limits of authorized funding. Numbers of target screenings will be predicated on program goals, past experience, available funds and local Social Services recommendation.

b. Provide funds to Public Health equal to the actual costs of rendering services under this agreement, such costs to include all state and local costs necessary to staff, equip and operate screening clinics, provide outreach services in selected areas, provide related activities and administer the screening program. Such funds are to be paid at periodic intervals on a mutually agreed to schedule, and are not to exceed amounts appropriated for EPSDT services.

4. Program Coordination

Designate a staff member to serve as EPSDT coordinator and liaison with Public Health and with the Division of Family Services, Social Services.

5. Auxiliary Services

a. At both central office and local levels, develop publicity for the program to increase client participation and facilitate clients' access to health care by assuring availability of medical/dental resources through adequate provider participation and arrangement of other services as needed.

b. Provide training for outreach necessary in the program, when outreach functions are performed by local departments of social services; and, as appropriate, coordinate efforts with Public Health in outreach training.

E. Medical Assistance and the Crippled Children Program

This section provides for casefinding and case management of crippled children eligible for Medical Assistance. It also provides for additional certification of certain facilities for the care of children eligible for Medical Assistance and delegation of the Title V fiscal intermediary responsibility.

The crippled children program is a state/federal funded program administered by Public Health, Bureau of Personal Health Services, Division of Services to Crippled Children (DSCC). The crippled children program is authorized by the Michigan Public Health Code (Act 368 of the Public Acts of 1978, as amended) to serve single or married individuals "under 21 years of age whose activity is or may become so restricted by disease or deformity as to reduce the individual's normal capacity for education and self-support". Cooperation between the Medical Assistance Program and the Crippled Children Program is required for effective delivery of services to those individuals eligible for both programs.

PUBLIC HEALTH WILL:

1. Determine which children in, or eligible for, the Medical Assistance Program qualify as crippled children under legislative mandate and Public Health's rules and procedures.

2. Provide case management including approval of physicians, hospitals and other providers for the provision of services, to those determined to be eligible for Crippled Children Program benefits. This management will be provided by physicians, nurses, and other health professionals in the central and regional offices that serve crippled children.

3. Utilize the same method of payment for services rendered to crippled children (including rates of reimbursement) used by Social Services to pay for services rendered to Medical Assistance recipients.

4. Provide to Social Services, on a timely basis, all information relating to eligibility, authorization and other information as required, which would enable invoices for services rendered to be processed for prompt payment.

5. Certify to Social Services hospitals and nursing-care facilities approved for the inpatient care of children eligible for Medical Assistance benefits.

6. Certify to Social Services the speech and hearing centers approved for

the evaluation of recipients suspected of being hard of hearing.

7. Prior authorize those selected services for Social Services program recipients which may from time to time be mutually agreed upon.

8. Provide to Social Services, on a timely basis, all reports necessary to fulfill federal reporting requirements.

9. Designate appropriate personnel to work on a Public Health/Social Services task force to examine issues of reimbursement, claims processing, cost-accounting, and systems development.

SOCIAL SERVICES WILL:

1. Determine the financial eligibility of children for whom application has been made for Medical Assistance and who are or have been determined medically eligible for assistance under the Crippled Children Program.

2. Serve as the fiscal intermediary, and make payments for covered services authorized by Public Health for eligible Crippled Children. Program recipients, and bring to the attention of Public Health for resolution, before payment, invoices for services that appear to be inconsistent with program requirements.

3. Provide Public Health with the opportunity to review modifications of standards used to authorize payments so that the standards may be justified or revised jointly before implementation.

4. Provide data processing support to maintain computer systems relative to eligibility, government and management reporting for Crippled Children Program activities as mutually agreed upon.

5. Provide reimbursement to Public Health for the cost of covered services provided in the Crippled Children Program's diagnostic clinics to individuals eligible for Medical Assistance in accordance with mutually agreed upon procedures.

6. Provide reimbursement to Public Health by interaccounting for the cost of medical management and prior authorization of services provided to children eligible for Medical Assistance.

7. Provide Public Health, on a timely basis, all reports necessary to fulfill federal reporting requirements.

8. Review with Public Health, in advance, all initial and final cost settlements for hospitals, which affect Crippled Children Program expenditures.

9. Review with Public Health, in advance, all gross adjustments as may be mutually agreed upon, which affect Crippled Children Program expenditures.

10. Designate appropriate personnel to work on a Public Health/Social Services task force to examine issues of reimbursement, claims processing, cost-accounting, and systems development.

F. Medical Assistance and Title V Projects

The purpose of this section is to provide for cooperative arrangements

between the program of projects administered by Public Health (Title V grantee) and the Medical Assistance Program. The program of projects carried out under Title V of the Social Security Act include:

Maternity and Infant Care
-- initial assessment and plan of care for duration of pregnancy
-- post partum care
-- nursing services
-- nutrition services
Intensive Infant Care
Health of Children and Youth
Family Planning
Dental Health of Children and Youth

These projects have as their purpose the reduction of infant mortality and morbidity and the reduction of the incidence of mental retardation and other handicapping conditions.

PUBLIC HEALTH WILL:

1. Promote cooperative program planning and monitoring efforts at the state and local levels.

2. Identify individuals in need of preventive, diagnostic, treatment and medical care and services.

3. Identify and refer to Social Services individuals who may be eligible for Medical Assistance Program benefits.

4. Provide or arrange for health care and services mandated by the program of projects incorporating appropriate diagnostic, preventive, prenatal, delivery and postnatal services, surgical and specialized perinatal services to the high-risk obstetrical patient and neonate including long-term development assessment; family planning counseling and medical services; medical and dental care for children and youth including screening, diagnosis, preventive services, treatment, correction of defects and aftercare.

5. In accordance with mutually agreed upon procedures, request from Social Services reimbursement for the cost of covered Medical Assistance care and services provided by Title V projects to individuals eligible for Medical Assistance.

6. Establish, maintain standards and guidelines for quality of health care rendered by Title V projects.

7. Certify to Social Services public providers of family planning services.

8. Designate hospitals, physicians, and transportation providers for eligibility for the newborn intensive care program.

9. Designate appropriate personnel to work on a Public Health/Social Services task force to examine issues of coordination, policy develop-

ment, quality assurance, and reporting and evaluation.

SOCIAL SERVICES WILL:

1. Promote cooperative planning at the state and local levels.

2. Determine the financial eligibility of individuals for whom application has been made for Medical Assistance.

3. Identify and refer individuals in need of health care and services available by and through Title V projects to Public Health.

4. Establish the scope of services and reimbursement levels available under the State Plan for Medical Assistance.

5. Reimburse, as first payor, the cost of care and services furnished by or through the Title V grantee to individuals eligible for Medical Assistance.

6. Designate appropriate personnel to work on a Public Health/Social Services task force to examine issues of coordination, policy development, quality assurance, and reporting and evaluation.

G. Trust Fund Procedures

This section provides a procedure for verification of compliance of trust fund records pursuant to Act 368 of the Public Acts of 1978, as amended, Sections 21321 and 21721.

SOCIAL SERVICES WILL:

1. Audit the patient trust funds on a continuing basis, concurrent with the financial audit of each Michigan nursing home.

2. At the conclusion of the audit, direct a written statement indicating evidence of compliance or non-compliance to Public Health.

PUBLIC HEALTH WILL:

1. Determine facility compliance with Act 368 of the Public Acts of 1978, as amended.

2. Support Social Services' budget request for the cost of the above audit functions.

ARTICLE IV

Assigned functions will be carried out by Public Health and Social Services in full compliance with Michigan's approved State Plan for Medical Assistance and the statutory and regulatory requirements of the Department of Health and Human Services. The respective responsibilities of Public Health and Social Services detailed in Sections A through G above are not meant to exclude any other delegations of function that are mutually agreed to and within the scope of this contract. Each section of this contract will be reviewed at least annually and, in the absence of revision, will be noted with the date of the review.

It is understood and agreed that the parties shall have the right to examine all physical records originated or prepared pursuant to this contract, including working papers, reports, charts and any other documentation arising out of this contractual relationship. Said records shall be made available for review by the parties upon reasonable notice. The parties shall, for three years, maintain all pertinent data, information, and reports. Any exchange or release of medical or eligibility information relating to recipients affected by this agreement shall be in accordance with state and federal confidentiality guidelines. It is also agreed by Public Health that it will assign appropriate professional health personnel when indicated to coordinate with financial auditors where questions regarding medical service to Medical Assistance recipients are identified.

ARTICLE V

In the performance of the functions, Public Health is not authorized and may not change, disapprove or delay action on any administrative decision of Social Services or otherwise substitute its judgment for that of Social Services as to the application of policies, rules and regulations promulgated or otherwise initiated by Social Services.

It is further agreed and understood between the parties that, in recognizing the ultimate authority of Social Services as the single State agency for those matters falling within that authority, Social Services shall solicit recommendations from Public Health in the development and implementation of Medical Assistance Program policies and procedures. However, decisions of Social Services within its authority shall be final and binding on all parties hereto.

ARTICLE VI

Term, Extension, and Termination: This contract supersedes any prior agreement between the parties and shall continue in effect for a period of one year from the date hereof. It shall remain effective for successive periods of one year each thereafter unless during any such period, this contract shall be cancelled in accordance with the terms contained herein. This contract may be terminated, when either party requests termination, by giving 90 days written notice to the other party of its intention to terminate.

ARTICLE VII

This instrument contains the entire contract between the parties and shall not be modified in any manner except by an instrument in writing executed by both parties. If any term or provision of this contract or the application thereof to any person or circumstances shall, to any extent, be invalid or unenforceable, the remainder of this contract, or the application of such term or provision to person or circumstances other than those as to which it is held invalid or unenforceable, shall not be affected thereby and each term and provision of this contract shall be valid and be enforced to the fullest extent permitted by law.

Maurice S. Reizen, M.D., Director
Michigan Department of Public Health

12-16-80
Date

John T. Dempsey, Director
Michigan Department of Social Services

12/26/80
Date